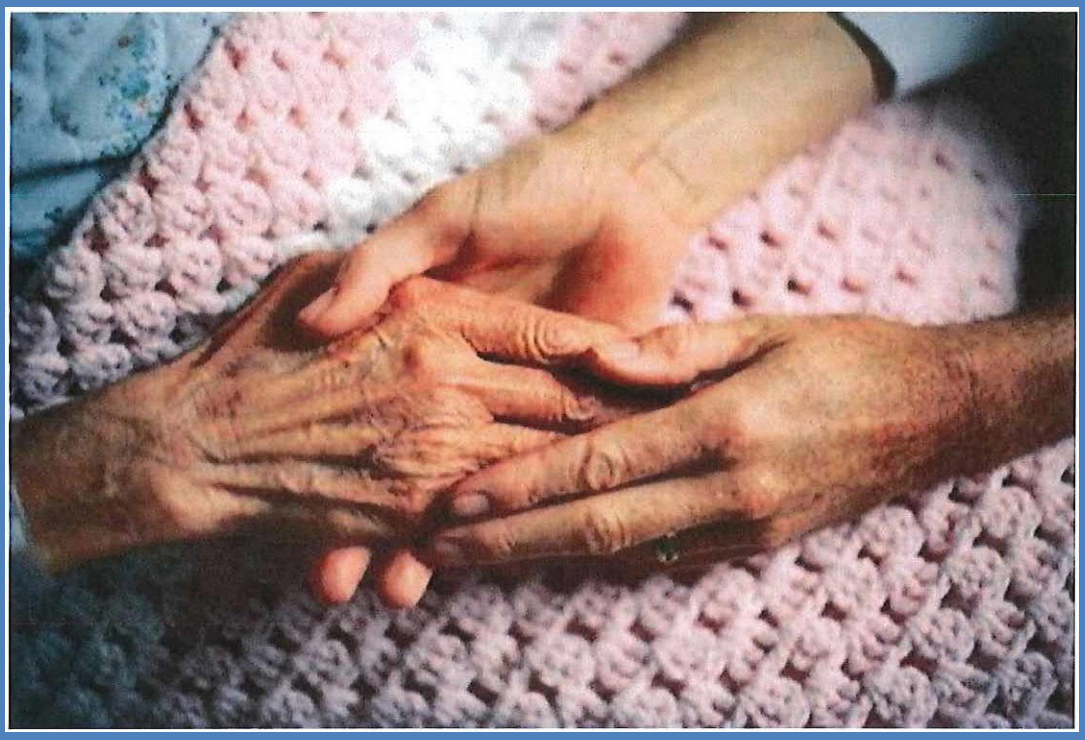

Assisted Living

Nurse Reference Guide

Idaho Department of Health and Welfare
Division of Licensing and Certification
Updated 7/2020

IDAHO DEPARTMENT OF
HEALTH & WELFARE

ASSISTED LIVING
NURSE REFERENCE GUIDE

Division of Licensing and Certification
Residential Assisted Living Facilities Program
Updated 07/2020

IMPORTANT DISCLAIMER: This document is only for reference and educational purposes. Please check the RALF website assistedliving.dhw.idaho.gov and IDAPA rules for RALF 16.03.22 for updates or changes. 7/1/20

Table of Contents

Definitions Used In Assisted Living Rules

Please refer to IDAPA 16.03.22.010, .011, & .012 for a complete listing of definitions.

Activities of Daily Living - Self-care actions necessary to sustain an individual in daily living, including bathing, dressing, toileting, grooming, eating, communicating, and managing medications.

Administrator - An individual licensed by the Idaho Bureau of Occupational Licenses as a Residential Care Facility Administrator.

Administrator's Designee - A person authorized in writing to act in the absence of the administrator who is knowledgeable of facility operations, the residents and their needs, emergency procedures, the location and operation of emergency equipment, and how the administrator can be reached in the event of an emergency.

Assessment - Information gathered that identifies resident strengths, weaknesses, risks, and needs, to include functional, social, medical, and behavioral needs.

Authorized Provider - An individual who is a nurse practitioner, clinical nurse specialist or physician assistant.

Behavior Plan - A written plan that decreases the frequency, duration, or intensity of maladaptive behaviors, and increases the frequency of adaptive behaviors.

Chemical Restraint - A medication used to control behavior or to restrict freedom of movement and is not a standard treatment for the resident's condition.

Core Issue - A core issue is any one (1) of the following: a. Abuse; b. Neglect; c. Exploitation; d. Inadequate care; e. A situation in which the facility has operated for more than thirty (30) days without a licensed administrator overseeing the day-to-day operations of the facility; f. Inoperable fire detection or extinguishing systems with no fire watch in place pending the correction of the system; or g. Surveyors denied access to records, residents, or facilities.

Division of Licensing and Certification - The section of the Department that is responsible for licensing and surveying residential assisted living facilities.

Inadequate Care - When a facility fails to provide the services required to meet the terms of the Negotiated Service Agreement, or provide for room, board, activities of daily living, supervision, first aid, assistance and monitoring of medications, emergency intervention, coordination of outside services, a safe living environment, engages in violations of resident rights, or takes residents who have been admitted in violation of the provisions of Section 152 of these rules.

Maladaptive Behavior - Any behavior that interferes with resident care, infringes on any resident's rights, or presents a danger to the resident or others. Involuntary muscle movements are not considered maladaptive behaviors.

Medication - Any substance used to treat a disease, condition, or symptom, which may be taken orally, injected, or used externally, and is available through prescription or over-the- counter.

Medication Administration - The process where a prescribed medication is given by a licensed nurse to a resident through one (1) of several routes.

Medication Assistance - The process whereby a non-licensed care provider is delegated tasks by a licensed nurse, to aid a person who cannot independently self-administer medications. See IDAPA 24.34.01, “Rules of the Idaho Board of Nursing,” Section 010.

Negotiated Service Agreement - The plan reached by the resident or their representative and the facility which outlines services to be provided and the obligations of the facility and the resident.

Non-Core Issue - Any finding of deficient practice that is not a core issue.

Nursing Assessment - Information gathered related to a resident’s health or medical status that has been reviewed, signed, and dated by a licensed registered nurse, as described in IDAPA 16.03.22.305.

Physical Restraint - Any device or physical force that restricts the free movement of, normal functioning of, or normal access to, a portion or portions of an individual's body, except for the temporary treatment of a medical condition, such as the use of a cast for a broken bone.

PRN - Indicates that a medication or treatment prescribed by a medical professional to an individual may be given as needed.

Resident - An adult, other than the owner, administrator, their immediate families, or employees, who lives in a residential assisted living facility.

Self-Administration of Medication - The act of a resident taking a single dose of their own medication from a properly labeled container and placing it internally in, or externally on, their own body as a result of an order by an authorized provider.

Survey - A review conducted by a surveyor to determine compliance with statutes and rules. There are two (2) components to a survey: (1) health care and (2) fire, life, and safety.

Surveyor - A person authorized by the Department to conduct surveys or complaint investigations to determine compliance with statutes and rules.

Therapeutic Diet - A diet ordered by a physician or authorized provider as part of treatment for a clinical condition or disease, to eliminate or decrease specific nutrients in the diet (e.g., sodium), to increase specific nutrients in the diet (e.g., potassium), or to provide food the resident is able to eat (e.g., a mechanically altered diet).

Unlicensed Assistive Personnel (UAP) - Staff, with or without formal credentials, employed to perform nursing care services under the direction and supervision of licensed nurses.

Licensed Professional Nurses' Responsibilities and Requirements

The following rules and information apply to nurses who work in assisted living facilities in Idaho. The rules for residential assisted living facilities in Idaho start with IDAPA 16.03.22. There is additional information and independent study courses on our website at www.assistedliving.dhw.idaho.gov. Be sure to check out the "Frequently Asked Questions" section while you're there. You can also call our assisted living surveyors at (208) 364-1962 Monday through Friday from 8 a.m. to 5 p.m. if you have questions, or you can email us at ralf@dhw.idaho.gov. Remember, nurses must also perform services in accordance with IDAPA 24.34.01, Rules of the Idaho Board of Nursing.

The facility must have on staff sufficient nursing personnel to meet the requirements of IDAPA 16.03.22.300.01 and 300.02, which state:

- A licensed Registered Nurse (RN) must visit the facility at least once every ninety (90) days to conduct initial and quarterly nursing assessments for each resident as described in Section 305 of the rules.
- The licensed Registered Nurse (RN) is also responsible for delegation of nursing functions (e.g., medication administration, blood glucose checks, catheter care, etc.), according to IDAPA 24.34.01, "Rules of the Idaho Board of Nursing," Section 400.
- In addition, the facility must ensure that a licensed nurse (RN or LPN) is available to address changes in a resident's health or mental status, review and implement new orders, and notify the physician or authorized provider when a resident repeatedly refuses to follow physician orders.

The licensed Registered Nurse must assess and document the following for each resident, including date and signature (see IDAPA 16.03.22.305):

Resident Health Status Assessments

The RN must assess each resident's health status, to include a physical assessment and identification of symptoms of illness or changes in the resident's mental or physical health status, prior to the resident's admission and at least once every 90 days thereafter.

The resident's initial nursing assessment must be completed prior to the resident's admission to the facility as part of the Comprehensive Assessment described in IDAPA 16.03.22.319. This initial evaluation should include an assessment of the overall resident's health, medical status, and identification of any health services needed, including frequency and scope. The initial nursing assessment (and subsequent quarterly nursing assessments) should include a complete physical examination of the resident, including vital signs, a skin assessment, etc.

A facility nurse must also assess the resident when there has been a change in their condition. Examples for a change of condition include, but are not limited to: a fall, altercation, or other unusual event involving a resident, a new diagnosis, a new wound, a change in mobility status, etc. The change of condition assessment should include a physical examination of the resident; for example, a physical examination by a nurse would be required after a fall to assess the resident for injuries.

According to IDAPA 24.34.01.460.02.a of the Board of Nursing rules, the Licensed Practical Nurse (LPN) may contribute to the assessment by collecting, reporting and recording objective and subjective data (such as after a fall). However, it is the RN's responsibility to complete each assessment and review the entire picture of the resident's health, including the physical findings, how they relate to current diagnoses and medications, what cares may need adjusted, any mental health needs the resident may have, etc.

Resident Response to Medications and Therapies

The RN must conduct a nursing assessment of each resident's use of, and response to, medications and prescribed therapies. The RN must monitor the resident for medication side effects, interactions, abuse, or other adverse effects. The nurse must ensure the resident's physician or authorized provider is notified of any identified concerns.

Current Medication and Treatment Orders

The RN must ensure the residents' medication and treatment orders are current and verify that:

- The medication listed on the medication distribution container, including as-needed (PRN)* and over-the-counter medications as appropriate, is consistent with physician or authorized provider orders, and the medication is available;
- The physician or authorized provider orders related to therapeutic diets, treatments, and medications for each resident are followed; and
- A copy of the actual written, signed, and dated orders are present in each resident's care record.
- The orders match the Medication Administration Record (MAR). This is an important step that is often missed. The medication aides rely on the MAR for accuracy, and the facility nurse should ensure that the orders match both the medication label/distribution container and the MAR.

*Remember, with PRN medications, a resident must be able to request the PRN medication, and the medication aide should have clear, set parameters to follow (for example: 1 tablet every 6 hours as needed for pain). The medication aide cannot carry out orders containing variables for which the medication aide would have to make a judgment call, such as "1-2 tabs" or "every 6-8 hours". If the resident is unable to ask for the medication, or the order requires a judgment decision, the facility RN (or home health/hospice nurse, if applicable) must be consulted for direction prior to the medication aide giving the PRN medication. Medication aides cannot make medical decisions or perform assessments. For example, if a resident is on hospice and no longer able to communicate but appears to be grimacing in pain or is restless, the medication aide would need to consult with a nurse prior to giving any PRN medication for pain or agitation.

Recommendations/Provider Notification

The RN must make recommendations to the administrator regarding any medication needs, other health needs requiring follow up, or changes needed to the resident's Negotiated Service Agreement (NSA). The nurse must ensure that the physician or authorized provider is notified of any identified concerns with medications and therapies, and the nurse must notify the physician or authorized provider of recommendations for medical care and services that are needed.

Progress of Previous Recommendations

The RN must conduct a review and follow-up of the progress on previous recommendations regarding any medication or other health needs that require follow up.

Self-Administered Medication

The RN must conduct an assessment on each resident who is participating in a self-administered medication program as follows:

- Before the resident can self-administer medication, to ensure the resident's safety (this includes residents who self-inject medications or have over-the-counter medications in their rooms).
- Evaluate the continued validity of the assessment every 90 days to ensure the resident is still capable of safely self-administering medication.
- If a couple lives in the facility, and one spouse would like to help the other spouse with their medications, the facility nurse would need to assess the spouse giving the medication, to be sure they are safe to do so. Then, the facility nurse should reassess the spouse every 90 days, to ensure the spouse continues to perform the medication administration for their spouse safely and correctly.

Resident and Facility Staff Education/Delegation

The RN must assess, document, and recommend any health care related educational needs, for both the resident and facility staff, as the result of the nursing assessment or at the direction of the resident's health care provider.

The nurse is also responsible for delegating tasks to unlicensed assistive personnel (UAP), as outlined in the Board of Nursing rules. If the facility employs an LPN, the facility RN can delegate UAP delegation to the LPN. Also, a home health or hospice nurse can delegate tasks to facility UAPs, with certain stipulations. Review IDAPA 24.34.01 and RALF FAQs.

Medication aides/UAPs must be delegated to assist with medications individually by the facility nurse, even if they have completed a medication course, and the delegation should include skill demonstration. Documentation of RN delegation must be in each employee's file. Delegation should be completed before the staff member assists residents with medications or other

nursing tasks (e.g. blood glucose checks, blood pressure checks, injections, etc.) and any time the facility's licensed nurse changes.

During the medication delegation, the nurse should ensure that all staff know how to respond to a resident who refuses or misses a medication, receives an incorrect medication, or when medication is unavailable or missing.

Other Rules Assisted Living Nurses Should Review

Comprehensive Assessment

According to IDAPA 16.03.22.319, prior to admitting a resident to a facility, certain portions of the Comprehensive Assessment must be completed, to include: resident demographics, level of personal assistance required by the resident, evaluation of the resident's maladaptive behaviors, and an initial nursing assessment. The remainder of the Comprehensive Assessment must be completed within fourteen (14) days of admission, and the results of the Comprehensive Assessment must be used to develop the NSA for the resident, identify training needs for staff, and evaluate the ability of a facility to meet the resident's needs.

Certification Requirement for Helping Residents with Medications

Before staff can begin assisting residents with medications, the staff must have successfully completed an Idaho Board of Nursing approved medication assistance course. This training is not part of the 16-hour minimum of orientation training or the 8-hour minimum of continued training per year (see IDAPA 16.03.22.645.) Staff training must include how the staff should respond to a resident who refuses or misses a medication, receives an incorrect medication, or when medication is unavailable or missing. Also remember, medication aides must be delegated to assist with medications individually by the facility nurse, even if they have completed the course, and the delegation should include skill demonstration. Documentation of RN or LPN delegation must be in each employee's file. Delegation should be completed before the staff member assists residents with medications or other nursing tasks and any time the facility's licensed nurse changes.

Medication Distribution System

According to IDAPA 16.03.22.310.01, each facility must use medi-sets or blister packs. The facility may use multi-dose medication distribution systems that are provided for residents receiving medications from the Veterans Administration or Railroad benefits. The medication system must be filled by a pharmacist and appropriately labeled in accordance with pharmacy standards and physician or authorized provider instructions. The facility's licensed nurse may fill medi-sets, blister packs, or other Licensing Agency approved systems (described in Section 39-3326, Idaho Code). The licensed facility nurse shall appropriately label the medication with name, dosage, amount and time to be taken, and special instructions if appropriate.

It is important to remember that:

- Medications must be kept in a locked area such as a locked box or room.
- Poisons, toxic chemicals, and cleaning agents must not be stored with medications.
- Biologicals and other medications requiring cold storage must be maintained at 38-45°F. The temperature must be monitored and documented daily.

Medication Assistance Must Comply with the Board of Nursing Requirements

- Medication must be given to the resident directly from the medi-set, blister pack, or medication container.
- Residents must be observed taking the medication.
- Medication aides cannot make assessment decisions, and all medication assistance must comply with the Board of Nursing requirements.

Discontinued and Expired Medications and Treatments

Per IDAPA 16.03.22.310.02, discontinued or outdated medications and treatments must be removed from the resident's medical supply and cannot accumulate at the facility for longer than 30 days. The unused medication must be disposed of in a manner that ensures it cannot be retrieved. The facility may enter into agreement, a copy of which must be maintained, with a pharmacy or other authorized entity to return unused, unopened medications to the pharmacy for proper disposition.

A written record of all drug disposals must be maintained in the facility and must include:

- A description of the drug, including the amount;
- The name of the resident for whom the medication is prescribed;
- The reason for disposal;
- The method of disposal;
- The date of disposal; and
- Signatures of the facility personnel who destroyed the medication and the witness.

Controlled Substances

The facility must track all controlled substances entering the facility, according to IDAPA 16.03.22.310.03. The tracking must include the amount received, the date, a daily count, reconciliation of the number given or disposed, and the number remaining. If a resident self-administers their medications, the RN does not need to do a daily count but should be checking any narcotics during the 90-day self-administration assessment. At that time, the nurse should verify the medications are being taken appropriately and ensure the resident is keeping the narcotics in locked storage.

Psychotropic or Behavior Modifying Medication (IDAPA 16.03.22.310.04)

If not used appropriately, psychotropic medications can compromise the health and safety of residents. It is important to remember that:

- Psychotropic or behavior modifying medication intervention must not be the first resort to address behaviors. Before initiating psychotropic medications, the resident's behavior(s) must be evaluated, a behavior management plan written and implemented, and data collected, which demonstrates non-drug interventions were attempted prior to the resident starting a new medication.
- Psychotropic or behavior modifying medications must be prescribed by a physician or authorized provider.
- The facility must monitor the resident to determine continued need for the medication based on the resident's demonstrated behaviors. (Each behavior must be documented, including the date and time, the specific behavior that was observed, the interventions that were used and the effectiveness of the interventions.)
- The facility must monitor the resident for any side effects that could affect the resident's health and safety.
- The use of psychotropic or behavior modifying medications must be reviewed by the physician or authorized provider at least every six (6) months (even for anti-depressant medications). The facility must provide behavior updates to the physician or authorized provider to help facilitate an informed decision on the continued use, and possible reduction of, psychotropic or behavior modifying medication. (There must be documentation showing that behavior updates, including quantitative data, were reported to the physician or authorized provider.)

Admission/Retention (IDAPA 16.03.22.010.11, 011.20, and 152.03)

The facility RN is required to perform an initial assessment of the resident, and only residents who meet the criteria in Section 152.03.a should be admitted. Additionally, the facility RN must be able to recognize prospective and current residents who may not be appropriate for admission/retention, as outlined in 152.03.b, and report that information to the administrator.

Written descriptions of the conditions for admitting residents to the facility must include the following stipulations:

- Residents will be admitted or retained only when the facility has the capability, capacity, and services to provide appropriate care, the residents do not require a type of service for which the facility is not licensed to provide or is unable to arrange for, and the facility has the appropriate number of personnel with the appropriate knowledge and skills to provide such services.

- No resident will be admitted or retained who requires ongoing skilled nursing or care that is not within the legally licensed authority of the facility. Such residents include:
  - A resident who had a gastrostomy tube, arterial-venous shunt(s), or supra-pubic catheter inserted within the previous 21 days.
  - A resident who is receiving continuous total parenteral nutrition (TPN) or IV therapy.
  - A resident who requires physical restraints, including bed rails.
  - A resident who is comatose. An exception is a resident who has been assessed by a physician or authorized provider who has determined that death is likely to occur within 30 days.
  - A resident who is on a mechanically supported breathing system, except for residents who use positive airway pressure devices only for sleep apnea, such as CPAP (Continuous Positive Airway Pressure) or BiPAP (Bi-level Positive Airway Pressure).
  - A resident who has a tracheotomy and is unable to care for the tracheotomy independently.
  - A resident who requires the use of a syringe to receive liquid or pureed nourishment directly into the mouth.
  - A resident with open, draining wounds for which the drainage cannot be contained.
  - A resident with a Stage 3, Stage 4, or unstageable pressure injury.
  - A resident with any type of pressure injury or open wound that is not improving bi-weekly.
  - A resident who has physical, emotional, or social needs that are not compatible with the other residents in the facility.
  - A resident who is violent or a danger to himself or others.
- For any resident who is assessed to require nursing care, the facility must ensure a licensed nurse is available to meet the needs of the resident.
- Residents who are not capable of self evacuation must not be admitted or retained by a facility which does not comply with NFPA Standard 101 as referenced in Section 004 of IDAPA 16.03.22.

Negotiated Service Agreement

In some facilities, someone other than the administrator is responsible for developing and updating the Negotiated Service Agreement (NSA). If this applies to you, review IDAPA 16.03.22.320. In nursing language, the NSA could be described as a care plan, as it should clearly describe all care the resident requires and who is responsible to provide the care. The nurse should make recommendations or additions to the NSA that will better help direct a resident's care. Review the following information regarding NSAs:

- The NSA must be completed and signed no later than 14 calendar days from the date of admission. In order for the caregivers to know how to care for a new resident, a written interim plan must be created and used while the NSA is being developed.
- The NSA provides for the coordination of services and instruction to the facility staff. Upon completion, the agreement must clearly identify the resident and describe the services that will be provided, the frequency of such services, and how such services are to be delivered.
- The NSA must be implemented.

- Each resident's NSA must be based on the Comprehensive Assessment as previously described, and it must incorporate information from the resident's care record as described in Section 330 of IDAPA 16.03.22.
- The resident and other relevant persons, as identified by the resident, must be included in developing the NSA. Licensed and professional staff must be involved in developing the agreement, as applicable.
- The administrator, resident and any legal representative must sign and date the NSA upon its completion. The resident (and their representative, as well as any legal guardian or conservator) must be given a copy of the signed agreement, and a copy must be placed in the resident's record no later than fourteen (14) calendar days from admission.
- The NSA must include the next scheduled date of review, i.e. in no more than twelve (12) months. The NSA must also be reviewed if there is a change in diagnosis or condition.
- Per IDAPA 16.03.22.320.07, the resident must be given the choice and control of how and what services the facility or external vendors will provide, to the extent the resident can make choices.

Outside Agency Care Plans

According to IDAPA 16.03.22.330.04.c.ix, the facility must have signed and dated copies of all care plans prepared by outside service agencies, including who is responsible for the integration of care and services. The administrator and nurse should be reviewing these care plans and outside agency notes so that coordination of care can occur, and to be sure it does not conflict with the resident's current NSA. Remember, an assessment by a home health or hospice nurse does not replace the facility nurse's assessment.

Infection Control (IDAPA 16.03.22.335, 625.01 and 625.03.k)

In some facilities, the RN may be responsible for providing training to staff on infection control or helping to develop policies and procedures. Review the following rules regarding infection control:

- Staff with an infectious disease must not work until the infectious stage no longer exists or must be reassigned to a work area where contact with others is not expected, and the risk of transmitting the infection is absent.
- All staff employed by the facility, including housekeeping personnel or contract personnel, who may come into contact with potentially infectious material, must be trained in infection control procedures for universal (standard) precautions, as outlined by the Centers for Disease Control and Prevention (CDC) at http://www.cdc.gov/hai/. Each staff should receive infection control training before they are allowed to work with residents.
- For both staff members and residents, any reportable disease listed in IDAPA 16.02.10, "Idaho Reportable Diseases," must be reported immediately to the local health district authority. Appropriate infection control procedures must be immediately implemented as directed by that local health authority.

Requirements for Handling Accidents, Incidents, or Complaints

Some administrators designate another employee to be responsible for investigating and reporting accidents and incidents. If this applies to you, review Subsections 215.08 of the rules for Residential Assisted Living Facilities (IDAPA 16.03.22).

Medical Gases (IDAPA 16.03.22.405.03)

The facility must ensure that portable oxygen tanks are handled, used, and stored in accordance with National Fire Protection Association (NFPA) standards.

Menu and Diet Planning (IDAPA 16.03.22.451)

As the facility RN assesses a resident's nutritional status, and makes recommendations regarding residents' dietary needs, it is important to be aware of the following:

- The facility must provide each resident with at least the minimum food and nutritional needs in accordance with the Recommended Dietary Allowances established by the Food and Nutrition Board of the National Academy of Sciences. These recommendations are in the Idaho Diet Manual, incorporated by reference in Section 004 of IDAPA 16.03.22. The menu must be adjusted for age, sex, and activity as approved by a registered dietitian.
- Snacks and fluids must be available and offered to residents between meals and at bedtime.
- The facility must have a therapeutic diet menu that is planned or approved, signed, and dated by a registered dietitian before it is served to residents. The therapeutic diet must:
  - Meet nutritional standards (to the extent possible).
  - Be planned as close to a regular diet as possible.
  - Be ordered by a physician or authorized provider (The facility must have a record of the order. Also, be sure to monitor to ensure the resident is consistently receiving the correct diet).

Residents' Rights

The administrator must ensure that policies and procedures are implemented to ensure that residents' rights are observed, promoted, and protected (Note: not all residents' rights are listed below, the entire set of residents' rights are listed from 550.01 through 550.23 of the rules for Residential Assisted Living Facilities). Since nurses are taught to advocate for residents, the following rules regarding residents' rights are important to know:

- Residents must be ensured the right to privacy, in regard to accommodations, medical and other treatment, written and telephone communications, visits and meetings of family and resident groups.
- Residents have the right to humane care and a humane environment, including:
  - A diet that is consistent with any religious or health-related restrictions.
  - Refuse a restricted diet.
  - A safe and sanitary living environment.

- Residents also have the right to be treated with dignity and respect including:
  - Being treated in a courteous manner by staff.
  - Being able to voice grievances with respect to treatment or care, without threat of retaliation, and with prompt effort by the facility to resolve grievances.
  - Be communicated with, either orally or written, in a language they understand.
  - Residents' personal and medical records must be kept confidential.
- Residents must have the right to be free from physical, mental or sexual abuse, neglect, corporal punishment, involuntary seclusion, and any physical or chemical restraints.
- Residents must have the right to control their health-related services including the right to:
  - Retain the services of a personal physician, dentist, and other health care professionals.
  - Select the pharmacy or pharmacist of their choice so long as it meets the statute and rules governing residential assisted living and the policies and procedures of the residential assisted living facility.
- Refusal of treatment does not relieve the facility of its obligations under IDAPA 16.03.22. If a resident refuses treatment or physician's orders, according to IDAPA 16.03.22.330.04.c.xii, the following must occur and be documented in the resident's record:
  - The resident and the resident's legal guardian have been informed of the consequences of the refusal.
  - The resident's physician or authorized provider has been notified of the resident's refusal (the facility may also have a policy that the facility RN be notified as well).

Staffing Standards (IDAPA 16.03.22.600)

The facility nurse may be asked to assist with staffing schedules. When creating staff schedules, the following should be considered:

- The facility is required to ensure that there are sufficient staff, during all hours, to meet the needs of the residents. For example, if there are residents who require two-person transfers, two staff members, who can assist with transfers, must be at the facility 24 hours a day.
- Staff must be up, awake, and immediately available for residents at all times, including during resident sleeping hours.
- If there are detached buildings/units on the facility campus, there must be at least one staff member present in each building/unit, at all times residents are present.
- At least one direct care staff, certified in first aid and cardiopulmonary resuscitation (CPR), must be present in the facility at all times (or one first aid/CPR trained direct care staff per building/unit, if there are multiple buildings/units on the campus).

Training Requirements for Facilities Admitting Residents with a Diagnosis of Dementia, Mental Illness, Developmental Disability, or Traumatic Brain Injury

A facility admitting and retaining residents with a diagnosis of dementia, mental illness, developmental disability, or traumatic brain injury must train all staff to meet the specialized needs of these residents. Any staff who have contact with residents must receive this specialized training within 30 days of hire or of admission of a resident with one of these

conditions. The means and methods of training are at the facility's discretion. In some facilities, the RN may conduct the training (although ultimately, it is the administrator's responsibility to ensure that all staff training is completed, per IDAPA 16.03.22.625). Please refer to rules 630.01 through 630.04 for the topics that must be covered. Additional information on staff training requirements can be found at IDAPA 16.03.22.154 and 625.

Record Information and Availability (IDAPA 16.03.22.310, 319 and 330)

Each facility may have different forms and methods for documentation. All documentation must be available for review, and the following is required for every resident's record:

- Entries must include:
  - Date, time, name, and title of the person making the entry. Staff must sign each entry made by them during their shift.
  - Resident care records must be available at all times to caregivers when on duty, and each entry into the care record must be completed by the person providing the care.
- All records, paper and electronic, must be safeguarded against loss, destruction, deletion, alteration and unauthorized use.
- All admission documentation must be retained, including:
  - The admission agreement and any financial arrangements
  - Resident's providers of choice with contact information
  - Prior history and physical completed no more than six (6) months prior to the date of the resident's admission
  - Signed copy of resident's rights
  - Physician or authorized provider orders that are current, signed and dated, including a list of medications, diet, treatments, and any limitations prescribed.
  - Signed interim care plan to use while NSA is being developed
  - Comprehensive Assessment
  - NSA, once developed/completed
  - Documentation that the resident has been informed of the facility's emergency procedures
  - Record of all personal property that the resident has entrusted to the facility
  - Any complaints/grievances voiced by the resident, as well as the investigation, outcome and facility response
- The facility must have behavior management records for residents, when applicable (see IDAPA 16.03.22.319.04 and 330.06). These records must document:
  - An assessment of the maladaptive behaviors
  - Behavior plan outlining at least one (1) intervention specific to each maladaptive behavior
  - Tracking:
    - Date and time each maladaptive behavior was observed
    - The specific behavior observed
    - What interventions were used
    - The effectiveness of the interventions

- Documentation of six-month review of psychotropic medications (section 310.04.e), as previously described.
- Care notes must be signed and dated by the person providing the care and services. Caregivers must document the cares they provide and their observations. It is not acceptable for nursing or administration to delete or destroy documentation or to document for caregivers. Care notes must include:
  - When the NSA is not followed, such as resident refusals of medication or times medication is not taken by a resident or not given to a resident, the reason for the omission, and the facility's response.
  - Delegated nursing tasks such as treatments, wound care, and assistance with medications.
  - Unusual events such as incidents, accidents, or altercations, and the facility's response.
  - Calls to the physician or authorized provider, the reason for any calls, and the outcome of the calls.
  - Notification of the licensed professional nurse of a change in the resident's physical or mental condition. (The facility nurse should document their follow-up to notifications of changes of condition.) All methods of communication must be retained in the resident's record, including e-mails and text messages between staff and the nurse/administrator.
  - Notes of care and services from outside providers, such as home health and hospice. (The nurse should review these notes to provide continuation of care and identify concerns; e.g., worsening pressure ulcers.)
- Nursing assessments, signed and dated, from the licensed registered nurse, which include the documentation requirements in IDAPA 16.03.22.300 and 305.
- The facility must have documentation of all PRN medication use, including the reason for taking the medication and the efficacy. Remember, a resident must be able to request the PRN medication, or the medication aide should have clear parameters to guide them, or the facility RN must be notified for direction prior to giving the PRN medication. Medication aides cannot make assessment decisions.
- Discharge records, including:
  - If discharge was involuntary, the facility's efforts to resolve the situation
  - The discharge notice and all required components (see IDAPA 16.03.22.217.04)
  - The date and location where the resident is discharged
  - Disposition of resident's belongings

NOTE: Please review IDAPA16.03.22.330 in its entirety, for additional records which must also be retained by the facility.

We hope that you have found this guide helpful. We encourage you to review the entire set of rules for assisted living facilities, as well as the "FAQ's", as these contain very practical answers to many questions a facility nurse may have. Otherwise, please feel free to contact our team with any questions. Thank you for caring for the residents in your assisted living facility!

Rules that are Incorporated into Assisted Living Rules

Americans with Disabilities Act Accessibility Guidelines. 28 CFR Part 36, Appendix A.
https://www.ada.gov/1991standards/adastd94-archive.pdf

Title 39 Chapter 33 Idaho Residential Care or Assisted Living Act.
https://legislature.idaho.gov/statutesrules/idstat/Title39/T39CH33/SECT39-3305/

IDAPA 16.03.22 Residential Assisted Living Facilities.
https://adminrules.idaho.gov/rules/current/16/160322.pdf

RALF FAQs.
http://healthandwelfare.idaho.gov/Portals/0/Medical/LicensingCertification/RALF_FAQs.pdf

Idaho Board of Nursing Rules. IDAPA 24.34.01, "Rules of the Idaho Board of Nursing."
https://adminrules.idaho.gov/rules/current/24/243401.pdf

Idaho Board of Pharmacy Rules. IDAPA 24.36.01, "Rules of the Idaho State Board of Pharmacy." https://adminrules.idaho.gov/rules/current/24/243601.pdf

Idaho Food Code. IDAPA 16.02.19, "Idaho Food Code."
https://adminrules.idaho.gov/rules/current/16/160219.pdf

Idaho Diet Manual. This manual is available for purchase at https://www.eatrightidaho.org/diet-manual/

Idaho Reportable Disease List.
https://healthandwelfare.idaho.gov/Portals/0/Health/Epi/IDAHO%20REPORTABLE%20DISEASE%20POSTERS_2018.pdf